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Discharged adolescent schizophrenics (17) and their families participated in a pilot program of multiple group counseling, planned to help ex-patients reintegrate into the community. Patients were selected prior to discharge and randomlly divided into three multiple-family groups. Each participating family had had a severe breakdown in the parent-child relationship in the areas of communication, mutual expectations, and interpersonal relationships. Three introductory sessions alllowed for observation of family cooperation and interaction. Weekly meetings were held for one year after discharge at a community center. Specific counseling goals were to: (1) improve parent-child communication, (2) change unrealistic parental expectations of the child, (3) lessen shame of family (hospitalization stigma), and (4) improve parental understanding and acceptance of their own and children's social roles. Advantages of multiple family counseling were: (1) families could compare themselves to other families, (2) activities allowed for family unit as well as individual member participation, (3) behavioral insights were shared, (4) social relationships were established by families, and (5) ex-patients developed an understanding of their parents. (NG)

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# MULTIPLE GROUP COUNSELING WITH DISCHARGED SCHIZOPHRENIC ADOLESCENTS AND THEIR PARENTS*

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# MULTIPLE GROUP COUNSELING WITH DISCHARGED SCHIZOPHRENIC ADOLESCENTS AND THEIR PARENTS

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One of the major areas in working with the younger ex-patient is the need on the part of the professional to utilize the family as a resource and as an aid in post-hospital adjustment to community life. In the search for new ways to deal with this area, multiple group counseling was initiated to help discharged patient and their families. Multiple family group counseling is an experience providing families and their adolescents with an opportunity to work on common problems, such as role conflict, values and inter-generational tensions. Although the multiple family group approach is not new, there exists a lack of experience with families including discharged schizophrenic adolescents.

Kimbro, et al, report working simultaneously with a group of adolescents and families in multiple family therapy. This was short-term therapy and consisted of 12 sessions of 1½ hour duration. The participants included 3 families and their adolescents who were having difficulty in school although they had good intellectual endowment. The author concluded that these sessions were helpful in developing extrafamilial adolescent-adult relationships.[1] A somewhat less structured demonstration is reported by Levin who combined hospitalized psychiatric patients from the ages of 16-63 with family members while patients were hospitalized in therapeutic

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family multiple groups. The observation indicated that these sessions were viewed favorably by the therapists as well as families and patients.[2]

A similar attempt at group treatment of families with schizophrenic sons has been reported by Fischer.[3] The sons were patients who attended a day treatment center at Veterans' Hospital and included the parents of the veterans. Judging from the age of the parents, the patients were probably in their twenties or thirties. The average length of this group experience was 8 months and the focus was reported as an examination of social interaction and family communication, rather than on repressed material or past events.

Elsa Leichter [4] has reported an experience with multiple family groups describing it as combining family and group therapy. The composition of the group consisted of 3 couples and 5 children between the ages of 8 to 16.

It can be seen therefore, that while a number of family therapy groups have been developed recently, few, if any, offered the structured experience which we describe below and which was used specifically to aid discharged schizophrenic adolescent patients.

In the last decade, several programs have been initiated, supported by Federal and private grants. We have come to realize that the development of Aftercare Programs to serve discharged patients has become a crucial area in helping the ex-patient to reintegrate into the larger community and to maintain reintegration.[5-6] This paper will describe a pilot aftercare project that was initiated by

Hillside Hospital and the Educational Alliance Community Center. Some of the problems confronting discharged patients and their families will also be described.

The agency of Hillside Hospital is a voluntary non-profit psychiatric institution with the capacity to serve 198 patients. The hospital, located in Glen Oaks, New York, admits both male and female adult in-patients of all ages and adolescent female patients between the ages of 13 and 17. Most of the referrals to Hillside Hospital are made by either physicians or voluntary agencies, or are self-referrals. The hospital is a non-sectarian institution whose aim is to serve psychiatrically ill persons who can benefit from a psychotherapeutically-centered treatment milieu within a year's time. In addition, an average of 130 persons receive out-patient treatment from the hospital's clinic which includes a children's therapy unit. Patients are admitted on a voluntary basis only. The hospital is also committed to training and research.

The Educational Alliance Community Center is a 76 year old non-profit, non-sectarian community center serving the greater metropolitan area and, in particular, its immediate neighborhood. The Center has an extensive and highly diversified program of social, recreational, educational, and cultural activities. Its population ranges in age from three years old to the elderly. Included among the services offered by the Center are examples such as a teen-age department, a department for the aged, a day school, nursery school, and a gym. The Educational Alliance also maintains many special projects which relate to the fields of mental and physical health

and welfare in the larger community. The Educational Alliance Community Center was chosen because of its ability to provide a supportive environment and atmosphere for creative performance and cooperation. The Center, with its vast social and creative resources, was introduced as the setting for future meetings and activities.

The Formation of the Groups

The idea of a pilot project of Multiple Family Counseling was introduced to four teams of four living units at Hillside Hospital. Each team consists of a supervising psychiatrist, psychiatric residents, nurses, recreational and occupational therapists, social workers and students. Discussions were held with the various teams, who reacted most favorably to the proposed project. Multiple Family Counseling was identified as an additional aspect in the hospital's aftercare treatment of the discharged patient and his family. It was felt that the creation of the family groups would enhance and fulfill our objectives for patients to improve communication and cooperation in the various areas of interpersonal and social relationships.

The families chosen to participate in the multiple family counseling group were parents of young patients in their last phase of hospital treatment, most of the patients were diagnosed at Hillside Hospital as schizophrenic. The sample of families consisted of seventeen pre-discharged patients from Hillside Hospital and their parents. The age range of the youngsters was 18-24; the ages of the parents ranged from 40-60. Prior to their discharge, the patients and their families were selected randomly and divided into three multiple

family group. All referrals to these groups were made by the unit social worker who, in collaboration with the treating psychiatrist, identified each family as suffering a severe breakdown in the parent-child relationship, mainly in the area of communication, mutual expectations, and interpersonal relationship.

The participants in the groups were acquainted with the objectives for this pilot project. They were familiarized with procedural matters such as the projected length of time and the content of and programs for the meetings. The program was planned for a period of one year, utilizing discussion groups, role playing, adult programs in a community center setting, outdoor recreation and any activity that would provide the group with the opportunity to improve communication through social interaction and cooperation through active work. All of the patients and parents agreed to participate in this project.

The families selected for counseling met at the hospital for three initial sessions. These sessions took place three weeks prior to the discharge of the patients who were joining the groups. The first meeting was an introductory one, to explore goals, which parents and patients identified as follows: 1) to increase communication, 2) to prevent isolation of the patient and his family after the patient's discharge, 3) to increase social interaction, and 4) to work on the conflicts which revolve around mutual expectations.

For the second session an O. T. worker was invited from the hospital to organize the group around various handcraft activities. The activities consisted of mosaic work, flower-making, woodworking,

etc. for the purpose of involving patients and their parents in working on a common goal. This session gave us a chance to observe for the first time the degree of cooperation and interaction between the patients and their parents. We noticed that the participants tended to group together by families.

The third session was also headed by an O. T. Worker who again involved the participants in creative activity. In this session we conveyed to the members of the group the idea of choosing any formation of sub-grouping that they wished. It was noticed that within the larger group of six families, most of the participants split from members of their own families and worked with family members of other sub-groups. During this session, we noticed a greater degree of cooperation on the part of the participants. Relating easily to others, they were able to reach out for a closer interaction with those both in the larger group and in their own individual family units.

The remainder of the meetings were held at the Educational Alliance Community Center. The groups were given an orientation to the center, to its activities, and to the community that it serves. The fourth session was open for reaction from the group which seemed to like the idea of having meetings in the Community Center. They expressed a particular need to be involved in activities and were most interested in the possibility of having a weekend trip to the Educational Alliance camp out of town.

The groups were seen for approximately one year in weekly sessions. The bulk of the sessions were discussion groups. In addition, the

Community Center's activities were fully utilized, including the camp grounds at Brewster. In the community center, the members of the groups participated in arts and crafts activities, social gatherings, and one-day trips on weekends to the Educational Alliance Camp. Such camp outings involved a great deal of mutual activity such as cooking out, ball-playing, swimming, boating, and other sports. During this year, these families and their younsters were provided with the opportunity to improve their social interaction, confront mutual difficulties, and delve into problems common to all of the families concerned.

Goals and Directions of the Counseling Sessions

In the multiple family therapy process we set outselves the aim of observing that the interaction of the ex-patients and their parents. We observed in the sessions that family interaction tends to maintain itself around some point of equilibrium. The family as an on going system is constantly aiming toward maintaining a degree of stability in this interaction. Occasionally, individual members in the family system will interfere with this equilibrium and affect both other members of the family and the entire system's stability.

We have observed among these families that problems affected by external reality, on a vocational, social, or educational level, caused anxiety and stress that was carried over into the group sessions. We have seen displacements of blame, hostility, and anger on the part of children toward their parents. On the other hand, parents expressed disappointment in their offspring because of their inability to adjust as fast as they, the parents, would have liked. The exchange of feelings, which was verbalized in some of our sessions,

brought about the development of a group process in which the participants were able to release anger, share experiences, identify problems and behavior, and do some creative thinking and readjustment.

Our goal was to focus on the conflictual areas of communication, expectation, hospital stigma and role confusion. Yet it was necessary to be flexible enough to help the family groups meet some of their own needs within the process. The initial meetings were primarily concerned with the parents' relationships with their children. Very rarely were the families ready to move from this topic and develop some insight into their own problems which might have been in part causative of their children's illnesses.

A pattern of denial on the part of the parents seemed to emerge as to their own problems and role in relation to their children. After a few sessions, however, the focus was shifted from a slow and unconscious defensive attitude toward a less defensive and more self-challenging process. This was heightened by the parents themselves who questioned their own role and responsibility as related to their children's problems and illnesses.

The issue of communication seemed to emerge as a major inhibitant to the parent-child relationship. This significant area is one in which parents demonstrated either support and understanding of their offspring or rejection and lack of understanding. This problem was also identified in reverse, in the ex-patients' communication patterns with their parents. The breakdown in communication led in many instances to distortion, misunderstanding, and the blocking of

feelings which created anxiety and frustration. This area was dealt with in our group meetings. Often, the group itself confronted one another, challenging both statement and reason. At times, the group leader had to intervene in order to clarify, interpret, and demonstrate how break-down in communication affects the family equilibrium. In one instance, the group leader confronted a family by exposing a network of communication which was distorted and indirective, and in which the father was not able to communicate with his son, utilizing his wife as a mediator.

Significant contributions were made by the participants. Some parents were able to quote themselves as having said "I don't understand this child. I can never get through to him". Some parents, particularly fathers in the group, wondered whether they were involved enough to take a major role in the upbringing of their child.

The network of disturbed communication patterns is an aspect of major importance and would indicate need for re-education and re-training through the group process.

The area of unrealistic, inappropriate timing of demands and expectations emerged as an additional barrier to the readjustment of the ex-patient and his family. The unrealistic expectations and pressure were usually exerted by the parents upon their son or daughter in the area of vocational, educational and social performance.

We have also observed the other extreme where parents had no expectations of, and made no demands upon their sons or daughters. They felt that their child was too ill and therefore unable to assume

any responsibility or involve himself in any training or habilitation program.

Both extremes were very often introduced into the group meeting. This was demonstrated in terms of a parent's demand for almost immediate adjustment to vocational situations, academic performance and social experience. Parents often pressured their child to socialize and make contact with young adults who had never been mental patients. On the other hand, some parents demonstrated an attitude of over-protectiveness which in many cases created a pattern of dependency of the young discharged patients upon their parents.

The third area of concern was identified as the stigma of hospitalization and the way in which it affected the patients and the families as well. A majority of parents and children felt ashamed of the fact of mental illness in the family because mental illness is a handicap that must be hidden. It was felt that these attitudes should be adopted because of society's ignorance and prejudice against mental illness. This concern is still heavy, despite the massive educational programs conducted by interested organizations.

Many parents also express anger and disappointemnt in their youngsters. They felt that their son's or daughter's illness was a hardship to their family and gave them a bad reputation. The discharged young patients in the group were very sensitive about their hospitalization and in some instances blamed their parents for having a share in their own illness.

The final problem, which was quite pronounced, was related to the need to deal with social role performance in terms of parental acceptance and understanding for themselves as well as for their children. Our sessions with the Family Group demonstrated the need to deal with different attitudes and values, mainly around family role models that ranged from traditional models of authoritarianism to permissive companionship models.

Some parents showed very little understanding that their ex-patient sons and daughters had virtually no experience in social role development. Many parents showed a great deal of resistance to an acceptance of their child's handicap and the probability that he would never achieve the kind of higher social role performance and status the parents might have hoped for. Most of the families needed help in terms of re-education and discussion about changing role patterns and behavior.

Role of the Group Leader

Before defining the role of the group leader, it must be stated again that the families selected to participate in the group were the ones in which the breakdown in relationships in the family constellation was the most severe. The younsters were the most marginal patients in the hospital and can be described as borderline in terms of their ability to function vocationally and socially.

The leader's role was to utilize his influence as therapist of the group. This influence was used to intervene in the group structure, and extend a greater degree of control when needed. The groups tended during the initial session to lose focus and concentrate on

unique, rather than on conventional problems. The therapist had to confront, interpret, and help the group process to move ahead. It was necessary to hammer out the nature of the conflicts presented, and to identify the sub-groups, the power structure, and be sensitive to the groups interactions and movement.

The group leader observed advantages of the multiple family counseling for participants. Some of these observation paralleled those already reported in the literature referred to above.

The most salient advantage to the families was their comparison and their observation of interactions with those of other family units. Dysfunctioning, homeostatic disequalibrium and maladaptive communication patterns could be compared. On the one hand, this created the feelings within some family units that they were coping with realities in a better manner than other families. On the other hand, families could adapt and modify their patterns in terms of what appeared to be to them, superior communicational system. In essence, each family unit was given the opportunity to learn by example.

The activity program served the purpose of enabling the families to participate both as family units and as a part of a whole. This type of activity participation tended to stimulate families as units to participate when they were reluctant to do so. The activity participation itself served to bring out ego strengths within each of the family members. Such successful participation furthermore, served as a stimulus for the ex-patients and for their parent to achieve a certain amount of gratification. This subsequently spilled

over into other activities. In this way, the activity itself acted as a catalyst.

In the course of the sessions, the family members were more apt to share behavioral insights concerning their kin when they noted that other families were involved in this process. The leader encouraged this type of sharing by pointing to the commonality of the problems and concerns. This was particularly true in the areas of expectations of parents and of the concern around the stigma of mental illness.

Perhaps one of the unique advantages that was observed by the group leader in this process was related to socialization patterns established by the parents and children alike. Our experience with young schizophrenic adolescents indicated they suffer from serious social deficit. Multiple family counseling served as a stimulus for this multiple family grouping to establish social relationships. These socialization patterns were established by the family members outside of the group sessions and for some it was the first time in many years that adequate socialization patterns had been established.

The family sessions also gave an opportunity to the young patients, most of whom had had great difficulty in controlling their hostility against their parents, to observe how other peers relate to their parents. These comparisons could be made and pointed out by the leader in terms of conflict, understanding or lack of understanding, reactions to reality stress, etc. The ex-patient was therefore, encouraged to develop understanding of the limits of his parents' behavior in terms of the ability of the parents to understand the ex-patient's problems.

In addition to being the group therapist in the traditional sense, he also has to select activities which could best dramatize the constructive potential of the families working together as units. In this connection, the outing experience was particularly helpful. The group leader needs to know relationship of specific types of activities and the use that the family members would make of these activities in terms of their own problems. For example, in some activities, family participation was notably different than in other activities. The leader could point this out.

In conclusion, the multiple family experience with schizophrenic adolescents seems to have served the purpose for which it was intended, namely; to help the young ex-patient modify behavior in terms of socialization patterns, to develop a more satisfactory network of communication within his family and to gain some understanding of the problems inherent in intra-familial communication patterns. It is evident that this is a limited experience and much needs yet to be done in terms of developing this as a validated technique for working with young adult schizophrenic ex-patients. However, the experience thus far has been promising.

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